



HEALTH CARE SERVICES, LLC

Phone: 952-683-1628

Fax: 952-683-1629

AUTHORIZATION FOR RELEASE OF INFORMATION

1.	CLIENT INFORMATION: Client Name: _____ Phone #: _____ Other names: _____ Date of Birth: _____ Address Street: _____ Apt #: _____ City: _____ State: _____ ZIP: _____												
2.	REQUEST Information from: Facility Name: _____ Fax #: _____												
3.	RELEASE OF INFORMATION TO: Facility Address Street: _____ Apt #: _____ City: _____ State: _____ ZIP: _____ Phone #: _____												
4.	RECORDS TO BE RELEASED: PCA ASSESSMENT AND SERVICE PLAN												
5.	<input type="checkbox"/> I AUTHORIZE THE RELEASE OF INFORMATION TO AMANI HEALTHCARE SERVICES LLC.												
6.	<table border="0"><tr><td>Signature of client/legally authorized Representative</td><td>Date</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td colspan="2">Relationship to Client</td></tr><tr><td colspan="2">_____</td></tr><tr><td colspan="2">Signature of witness (Verbal Authorization Only)</td></tr><tr><td colspan="2">_____</td></tr></table>	Signature of client/legally authorized Representative	Date	_____	_____	Relationship to Client		_____		Signature of witness (Verbal Authorization Only)		_____	
Signature of client/legally authorized Representative	Date												
_____	_____												
Relationship to Client													

Signature of witness (Verbal Authorization Only)													
